Plan First
Virginia's Family Planning Program for Men and Women

Agency use only:
Application: ☐ New ☐ Renewal
Case # _____
Eligibility Worker _____

If you need assistance completing the application, please contact your local Department of Social Services.

Plan First is a program which pays for family planning services and is available for those who are not eligible for full health care coverage. You may be eligible for full health care coverage if you are pregnant, or if you are age 18 or under. If you think this may apply to you, please complete the Health Insurance for Children and Pregnant Women application available online at www.famis.org or at your local Department of Social Services.

Step 1

Tell us who is completing the application, where you live, and where you get your mail.

First Name	MI	Last Name	Phone Numbers	Preferred Language (See Instructions)
		(Suffix)	H ( ) W ( ) Other ( )	

Address	Apt No.	City	State	Zip	City/County of Residence
(Street)					
(Mailing)					

Step 2

Tell us about yourself, your spouse, and any children under 21 years of age who live in your home.

	Person 1	Person 2	Person 3	Person 4
Name (first, MI, last)	(Suffix)	(Suffix)	(Suffix)	(Suffix)
Relationship to applicant	☐ Self	☐ Spouse ☐ Child ☐ Step-child ☐ Other (ex. Grandchild, sibling, etc.)	☐ Spouse ☐ Child ☐ Step-child ☐ Other (ex. Grandchild, sibling, etc.)	☐ Spouse ☐ Child ☐ Step-child ☐ Other (ex. Grandchild, sibling, etc.)
Date of Birth & Sex	_____ Month/day/year ☐ M ☐ F	_____ Month/day/year ☐ M ☐ F	_____ Month/day/year ☐ M ☐ F	_____ Month/day/year ☐ M ☐ F
Applying for Plan First?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Step 3

Provide the following information only for persons applying for Plan First.

	Applicant #1	Applicant #2	Applicant #3
Name			
Social Security #:			
Does this person have health insurance? (See instructions for further explanation)	☐ Yes ☐ No If **Yes**, please provide: Type of Policy: _____ Company Name: _____ Policy ID# _____	☐ Yes ☐ No If **Yes**, please provide: Type of Policy: _____ Company Name: _____ Policy ID# _____	☐ Yes ☐ No If **Yes**, please provide: Type of Policy: _____ Company Name: _____ Policy ID# _____
Person's Race, see codes below:	**Race Code #** _____	**Race Code #** _____	**Race Code #** _____
	Race Codes: **1** White; **2** Black or African American; **3** American Indian/Alaskan Native; **4** Asian; 5 Spanish American/Hispanic; **6** Native Hawaiian or Other Pacific Islander; **7** Asian & White; **8** Black/African American & White; **9** Other or Unknown; or **A** Asian & Black/African American		
Person's Ethnicity	**Hispanic/Latino** ☐ Yes ☐ No	**Hispanic/Latino** ☐ Yes ☐ No	**Hispanic/Latino** ☐ Yes ☐ No
Is this person a U.S. Citizen? (See instructions)	☐ Yes ☐ No If **yes**, please provide City, County and State/Country of Birth _____	☐ Yes ☐ No If **yes**, please provide City, County and State/Country of Birth _____	☐ Yes ☐ No If **yes**, please provide City, County and State/Country of Birth _____
If the person is not a U.S. citizen complete this section.	Alien/INS# _____ Date entered U.S. _____ Country of Birth: _____	Alien/INS# _____ Date entered U.S. _____ Country of Birth: _____	Alien/INS# _____ Date entered U.S. _____ Country of Birth: _____
Has this person had a procedure that now prevents pregnancies? (tubes tied, hysterectomy or vasectomy)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Step 4

Tell us about your income, the income of your spouse (if you are married and living together), and your parents' income if you are under the age of 21 and live with your parents.

Person Receiving Income	Employer's Name or Source of Income	How Often is Income Received?	How Much Gross Income is Received?
(First Name, MI, Last Name, Suffix)	Name of Employer	☐ weekly ☐ twice a month ☐ every two weeks ☐ monthly ☐ yearly	$
(First Name, MI, Last Name, Suffix)	Name of Employer	☐ weekly ☐ twice a month ☐ every two weeks ☐ monthly ☐ yearly	$
(First Name, MI, Last Name, Suffix)	Name of Employer	☐ weekly ☐ twice a month ☐ every two weeks ☐ monthly ☐ yearly	$
(First Name, MI, Last Name, Suffix)	Name of Employer	☐ weekly ☐ twice a month ☐ every two weeks ☐ monthly ☐ yearly	$

Step 5

Tell us about childcare or adult daycare expenses:
Do you pay someone to provide childcare or adult daycare while you work? ☐ **Yes** ☐ **No**

Full Name of person in daycare				
	How much do you pay?______ How often? ______	How much do you pay?______ How often? ______	How much do you pay?______ How often? ______	How much do you pay?______ How often? ______

Step 6

Voter Registration

Check one of the following:
( ) I am not registered to vote where I currently live now and would like to register to vote here today. I certify that a voter registration application form was given to me to complete. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote today.
( ) I do want to apply to register to vote. Please send me a voter registration form.
Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

Agency Use Only: Face-to-face interview not required. ☐ A voter registration form was mailed. Date mailed:

Step 7 Release of Information

Would you like to name a person who could apply for Medical Assistance benefits or receive correspondence and notices for you?
☐ Yes ☐ No If yes, please provide the following information in the space provided below.

Name of Representative _____ Phone Number _____

Address (Street, P.O. Box, etc.) _____ City, State, Zip _____

I want this representative to:

- ☐ Apply for and/or renew Medical Assistance
- ☐ Receive requests for information needed to determine eligibility
- ☐ Receive letters regarding actions taken on my case
- ☐ Other (specify):

Step 8 Signature

Note: ***We cannot process this application unless it is signed.***

By signing below I certify that I have read my Rights and Responsibilities (located on the instructions page) and agree to all the conditions and terms. I also agree that all the information I have given on this application is true and correct to the best of my knowledge and belief. I also understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, health insurance coverage may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

SIGNATURE (REQUIRED) _____ DATE _____

Application Instructions & Rights and Responsibilities

This application may be used for men and women applying for benefits through Plan First.

How do I apply?

To get started, simply complete this application and mail, drop off, or fax to the **local Department of Social Services (DSS)** in the city or county in which you live. If you need assistance completing the application, please contact your local DSS.

If you are under age 19 or pregnant:
The Health Insurance for Children and Pregnant Women Application is used to apply for full benefit medical assistance for children under age 19 and pregnant women. This application is available on-line at: **www.famis.org** *or at your local Department of Social Services.*

If you are age 19 or older:
The Plan First Application is used to apply for medical assistance limited to family planning services. You may use this application to apply for Plan First for yourself and/or your spouse with whom you live. You may also designate someone to apply on your behalf (authorized representative).

A person can not choose to be enrolled in Plan First if he/she is eligible for full benefit medical assistance.

Step 1
Information on person completing application

Complete this section listing your name, address, city/county of residence and phone number. Please list the address you want Plan First information to be mailed to in the mailing section. Please indicate which phone number we may call you at if needed, regarding your Plan First application. Please tell us the language you speak. Write the name of the language in the space provided, such as: English, Spanish, Vietnamese, Farsi, Korean, Kurdish, Arabic, Urdu, Russian, or any other language.

Step 2
Information on applicant and other family members in the home

Provide information on you, your spouse, and all children under 21 who live in the home with you even if they are not applying for Plan First. Check whether you are applying for Plan First for each person listed in Step 2. Although you can only apply for persons 19 years and older on this form, we need information on all children under 21 living in your home to correctly determine the size of the family. If there are more than 3 children under age 21 in the home, complete Step 2 on another application and attach it to this one. For each child under age 21 in the home, please write the child's name, the child's relationship to you, the child's date of birth, and check if the child is male or female.

Step 3
Information about persons applying for insurance

Answer all the questions in the column, if you are applying for Plan First insurance for this person.

Enter the **Social Security number** for each person applying for Plan First. A Social Security number is required for all persons applying for Plan First.

Check for each person whether or not they have other health insurance coverage now. Having other health insurance may affect a person's eligibility for Plan First. If the person has health insurance now, list the type of policy. (For example, comprehensive coverage, major medical, military-sponsored health care, specified disease coverage, dental only or vision only coverage, etc.) Provide the name of the insurance company and the policy number.

Persons are not eligible for Plan First if they have major medical coverage, even if it does not include family planning benefits.

Enter the correct code number for each person's race. Codes are listed below the question on the application. Then check yes or no if he/she is of Hispanic/Latino ethnic origin.

If the person is a U.S. citizen check yes. If the person is a legal immigrant, provide the person's Alien/INS #, country of birth, and the date the person entered the U.S. Some adults who are legal immigrants may qualify for Plan First. You must provide a copy of the front and back of the person's Resident Alien Card or other proof of immigration status with this application. If the person is a U.S. citizen and qualifies for Plan First, you may be asked to provide proof of his/her citizenship and identity.

Check yes or no depending on if the person has had a procedure that now prevents a pregnancy, such as a tubal ligation, hysterectomy or vasectomy. Anyone who has had a sterilization procedure is not eligible for Plan First.

Step 4
Income

Please list the name and the source of income for yourself and your spouse (if married and living together). If you are under age 21 and live with your parents, you will need to include your parents' income information along with your own.

If the income is from a job, list the name of the employer. If the income is from another source (such as unemployment compensation, Social Security, etc), write the type or source of the income.

For each type of income listed, check how often it is received (each week, every two weeks, twice a month, once a month, or yearly) and write the gross amount of income received each time. Be sure to write the amount of income before any taxes or other deductions are taken (gross income).

You also need to provide **proof of each type of income** for each source listed above. You will need to provide proof of all income received in the prior month before you apply or the most recent 4 week period. (For example, if you were applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May, you would need to provide proof of all income for April.)

To provide proof of income from a job, please attach a copy of all paycheck stubs for the month before you apply or the most

recent 4 week period showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much (gross pay) the employee was paid for each pay period for that month, or you may contact your local DSS agency to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or provide business records. You may be asked to provide records from the last three months up to the last year.

You must also provide proof of other types of income received. Examples of **proof of other income** include:

- Social Security (SSA or SSI) or Veteran's benefits - the current year award letter from the Social Secuity Administration or the VA;
- Unemployment compensation - a print out from the Employment Commission of all payments for the last month, benefits award letter, or a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call your local Department of Social Services.

Step 5
Childcare or Adult Daycare Expenses

Certain child and adult daycare expenses may help a person qualify for Plan First. Tell us if you **pay for childcare or adult daycare while you work**. If the answer is yes, write the name of each person in daycare, how much you pay for their care, and how often you pay it. (For example: $50 a week or $200 a month.) You can even report this expense if you are paying a relative to care for the children. The adult daycare expenses must be for an incapacitated spouse or parent of the person applying for health insurance.

Step 6
Voter Registration

Please follow instructions on application. Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential.

Step 7
Release of Information

If you would like someone else to provide or receive information on your behalf, **clearly print the person's name, the address, and phone number** in this section. We will not release any information about this application to anyone except you, unless you tell us who you want to be able to receive this information.

Step 8
Signature

Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application**. We cannot process an application without a signature.

Final checklist:
Did you answer all the questions?
Did you attach proof of all of last month's income?
Did you attach any other necessary documents?
Did you sign the application?

Mail, fax or drop off the application at your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES
(Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law.
- File a complaint if I feel I have been discriminated against. Request, in writing, a hearing or review of any negative action that affects eligibility for or receipt of Plan First benefits. This includes timely decisions made on this application.

I further understand and agree that:

- The State and its contractors may contact other State and Federal agencies to verify any information that affects eligibility for coverage of the persons applied for on this application.
- The State and its contractors may exchange information on this application and medical, health, or other information relating to the person's coverage with other agencies and contractors to assist with application, enrollment, administration, quality control, and quality assurance.
- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by the persons.
- Each provider of medical services to the person may release any medical or other information necessary for the provider to be paid.

As an enrollee in Plan First, I understand:

- I may be held responsible for paying for payment of any service not covered by Plan First.
- I must report any changes in the information provided on this application within 10 calendar days to my local Department of Social Services agency.
- Plan First must be renewed at least **every 12 months**. It is very important that you report any change in your address to the DSS agency that is managing the case. If we do not have a correct address, we will not be able to notify you when it is time to renew coverage and the person will be cancelled from the program.

Help us maintain coverage - tell us if you move!